

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

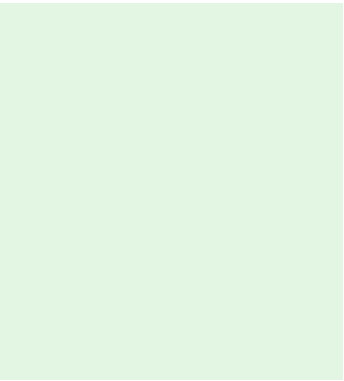
Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Current Performance as stated on QIP 2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	<p>5 Day Wait Time - Personal Support for Complex Patients: % of complex patients who received their first personal support service within 5 days of the service authorization date</p> <p>(%; Home Care patients; October 2016 – September 2017; HSSO CHRIS, HSSO DAD)</p>	88.0%	95.00%	88.7%	<p>In 2018/19, NSM LHIN in partnership with our service provider organizations, maintained a focus on the improvement of our cycle time from patient available date (PAD) to first visit. Though we have not reached our stretch target of 95%, continued improvement in our performance has been demonstrated. Personal Support (PS) capacity issues within our region leading to service delays continue to be the major contributing factor to patients not being seen within 5 days or less. An organizational project continues to focus on identifying long term, sustainable strategies to improve the match between personal support supply and demand. Though Q1 and Q2 2018/19 showed sustained improvement in this indicator, it is expected that in Q3</p>

and Q4 we will see a decrease in our results, with an increase in wait time for service. For 2019/20, this indicator will not be included in the QIP, but will be monitored through our internal performance reporting.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Year's QIP (QIP 2018/19)	Was this Change idea implemented as Intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Implement initiatives that reduce the gap between personal support (PS) supply and demand and have been identified and prioritized through engagement with community partners across all community sectors (Long Term Care, Community Support Services, Home Care)	Y	Several initiatives have been initiated in 2018/19 with a focus on reducing the gap between PS supply and demand across the region: <ul style="list-style-type: none"> • Partnered with patients and families through the 'Help US Help You' initiative; a communication toolkit to support Home and Community Care (HCC) staff to proactively support conversations with patients and families regarding their functional abilities and need for personal support services. • Currently piloting a shift based model of PS in two retirement homes with aim of improving access to residents, and consistency and continuity of care. • Maximizing existing health care resources in the community including the expansion of the paramedicine program, selective substitution of nursing and implementation of a kinesiology based program to optimize patients' functional independence. • Engaging extensively with Personal Support Workers (PSWs) to identify opportunities for positive change. • Collaboration with educational institutions to minimize barriers to accessing PSW educational programs. • Engagement of Long Term Care Homes (LTCH) to understand PS capacity issues and create a forum for LTCH administrators to potentially



share ideas and create a community of resources.

- A Personal Support Capacity Dashboard has been created to track key indicators associated with PS capacity that are reported monthly to the Executive Management Team and to the Board.
- Championing change at a provincial level through the release of a PS report that contains our LHIN's best advice to the Ministry regarding PS supply and demand.

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2	<p>Safety: % of Home Care patients who responded "Agree"/"Strongly Agree" to the following patient experience survey questions:</p> <ul style="list-style-type: none"> • Satisfied with support from Care Coordinator(CC) to address safety concerns • Satisfied with support from Service Provider (SP) to address safety concerns <p>(%; Home Care patients; April 2016 - March 2017; CCEE Survey)</p>	91.8%	92.2%	91.9%	<p>NSM improved slightly on this indicator over the previous year, reaching its target in both Q2 and Q4 2017/18. In working to improve patient safety, NSM continues to evolve opportunities to share the quality outcomes from patient safety events with staff, as well as promoting a culture of safety by recognizing staff who identify and report near miss events through the implementation of our Good Catch Award.</p> <p>The Client & Caregiver Experience Evaluation (CCEE) survey has been transitioned to a new vendor and survey collection for this current fiscal year (2018/19) was not initiated until January 2019. Results for this fiscal year are therefore not available.</p>

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Continue to evolve opportunities to share the quality outcomes from patient safety events with staff	Y	NSM continues to share Quality of Care Review outcomes and recommendations with the Patient Safety Committee and includes quality outcomes as part of patient safety education. As there was a slight decline in the percent of Care Coordinators responding positively to the question, "Staff are usually given feedback about changes put into

Promote a culture of safety by recognizing staff who identify and report near miss events through the Good Catch Program

Development and implementation of the "Safety and Service Issues Framework - Risk to Patient"

Collaborative approach with health system partners to review critical incidents at a system level

Y

place based on incident reports”, on our patient safety culture tool, this will be a continued focus on our 2019/20 QIP.

Work was done this fiscal year on enhancing the reward and recognition components of the Good Catch Program. Staff who submit near misses are being recognized quarterly in the organizational staff newsletter and at staff education days. Service provider organizations are informed of their staff who have identified a near miss so they can follow up with recognition within their organizations.

Y

NSM has successfully updated the "Safety and Service Issues Framework" to include risk to patient in addition to risk to staff/service providers. This is a decision-making framework to minimize patient and staff/service provider risk. Education was provided to both staff and service provider organizations.

Y

NSM has completed joint Quality of Care Reviews in collaboration with two hospitals within the region. Through the Regional Patient Safety Committee, with representatives from all hospitals and the LHIN, shared policies and procedures to support joint reviews are being developed and recommendations from joint reviews are shared with committee members to support learning and improvement in patient safety across the region.

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3	<p>Palliative Patient Experience: % of caregivers of palliative patients who responded "Good", "Very Good", or "Excellent" on a five-point scale to the following question on the Caregiver experience survey:</p> <p>Overall, and taking all services, in all settings into account, how would you rate his/her care in the last 3 months of life?</p> <p>(%; Home Care patients; April 2016 - March 2017; Caregiver Voices Survey)</p>	91.7%	91.7%	92.0%	Exceeding our target, 92.0% of caregivers of palliative patients reported a positive experience with overall care (2017/18 results). These positive results continue into Q1 and Q2 2018/19. As of Q1 2018/19, the caregivers of patients who died in residential hospice are now being surveyed and are included within these results.

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In collaboration with the community care team, Primary Care and the Palliative Care Network, clarify and document the roles and responsibilities of each care team member for sharing with patients/caregivers	Y	Work is being done provincially with the Regional Palliative Care Network (RPCN) to clarify roles and responsibilities of health care providers and identification of core competencies. Once released, NSM will then begin to align with this work, identify any gaps within sub-regions and develop a "contacts" document to share with patients. Work on this initiative will continue into 2019/20 and has been included in next year's QIP.

A shared information package for use by the care team that can be individualized to meet the specific needs of each patient/family. To include all relevant End of Life information (medication, stages of death, symptom management, etc.)

Y Work is being provincially, and by the Regional Palliative Care Network (RPCN), to develop tools to support the care team in sharing individualized information. This tool kit will be shared within the NSM region and NSM will work to identify any gaps within sub-regions prior to implementation.

In collaboration with our community palliative care partners, evaluate the Shared Care Team pilot implemented in Q4 17/18 in South Georgian Bay to inform future improvements

N This initiative has not been formally evaluated at this time. While evaluation tools have been developed, this initiative is not being led by NSM LHIN.

Standard process for documenting preferred place of death throughout the patient's care

Y Though a standard process for documenting preferred place of death is in place, NSM did not reach the target for percent of patients who died in their preferred place of death. The Coordinated Care Plan (CCP) project will be initiated in January 2019 and will continue into the next fiscal year. The CCP is an active plan and updated in real time with a copy made available to the patient. Once the CCP is active for all palliative patients, an improvement initiative within the 2019/20 QIP, "Preferred Place of Death" will be documented within the plan. As well, enhancements to our patient information system (CHRIS) will ensure this information is entered and reported on electronically.

Expand use of Caregiver VOICES survey to include caregivers of patients who died in residential hospice

Y Effective Q1 2018/19, the caregivers of all Home and Community Care patients who passed away in residential hospice are included in the Caregiver VOICES Survey. Results will be provided both semi-annually and annually to the residential hospices within our region through the Regional Palliative Care Network.

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4	<p>Patient/Caregiver Experience: Percent of Home Care patients who responded "Good", "Very Good", or "Excellent" on a five-point scale to any of the patient experience survey questions:</p> <p>i) Overall rating of LHIN Home and Community Care services</p> <p>ii) Overall rating of management/handling of care by Care Coordinator</p> <p>iii) Overall rating of service provided by the service provider</p> <p>(%; Home Care patients; April 2016 - March 2017; CCEE Survey)</p>	91.3	92.2	91.6%	<p>Results for this indicator improved slightly over the previous year achieving 91.6% in 2017/18. Though the target was not achieved, the target was exceeded in Q3 2017/18.</p> <p>The Client & Caregiver Experience Evaluation (CCEE) survey has been transitioned to a new vendor and survey collection for this current fiscal year (2018/19) was not initiated until January 2019. Results for this fiscal year are therefore not available.</p>

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Implement initiatives to achieve our ideal future culture as identified through our all staff culture workshop under the leadership of our Employee Engagement Advisory Team (EEAT)	Y	The NSM Employee Experience Advisory Team (EEAT) prioritized 12 initiatives identified through staff engagement that focused on improved organizational culture. Seven were implemented as of Q2 2018/19 and three other initiatives are currently in progress. Staff are updated at quarterly meetings and through the internal weekly newsletter as to the progress on

Core competencies framework for Care Coordinators with a focus on: assessment, care planning accountability and sustainability

Y

our culture initiatives. Our focus on organizational culture continues to be a priority on our 2019/20 QIP.


The Core Competencies framework was developed and launched in May 2018. This framework consists of eight Core Competencies for Care Coordination. Since the launch of this framework, education provided at HCC education days are linked to specific Core Competencies. In Q2 2018/19, work was done to incorporate the Core Competencies framework into the performance review process for HCC staff, which went live in Q3 2018/19. A Core Competencies poster has been developed, shared with all staff, and made available on the Professional Practice Share Point site. Education and coaching related to the Core Competencies framework is also a component of the onboarding process.

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5	<p>Hospital Readmission: Percentage of Home Care patients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital</p> <p>(%; Home Care patients discharged from hospital; July 2016 – June 2017; HSSO HCD, CIHI DAD, CIHI NACRS)</p>	17.8%	17.8%	<p>18.0% Q1 2017/18 - Q4 2017/18</p> <p>(will be updated when results available for Q2 2017/18 – Q1 2018/19)</p>	<p>In 2018/19, NSM LHIN collaborated with several of our community partners within the NSM LHIN sub-regions with a shared goal of reducing readmissions of patients with Chronic Obstructive Pulmonary Disease (COPD). Specifically within the Couchiching sub-region, in collaboration with the Orillia Soldiers Memorial Hospital (OSMH), Family Health Team (CFHT) and Health Link, a collaborative QIP dashboard was created that identified each organization's change initiatives and allowed us to monitor our individual progress to our collective goal. Our hospital partner (OSMH) was able to reach their readmission target specific to this patient population. Work will continue into 2019/20 to meet a shared target in reducing readmission rates for patients with congestive heart failure (CHF) through increased referrals to community support, such as Telehomecare and the CHF clinic.</p>

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Expansion of the E-Notification process currently used at Royal Victoria Regional Health Centre (RVH) to other hospitals within NSM	N	Led by the LHIN Digital Health lead, NSM continues to encourage hospital sites to participate in this initiative. This continues to be a priority, but is dependent on engagement from the hospital sites. No further expansion has occurred at this time, though this remains a priority for the LHIN into the next fiscal year.
In collaboration with one of our hospital partners (GBGH), pilot a process to ensure discussions with patients regarding their medications occurs prior to hospital discharge	Y	The Patient Oriented Discharge Summary (PODS), which includes the discussion of medications prior to hospital discharge, has been rolled out successfully by Georgian Bay General Hospital (GBGH) in partnership with HCC. A portion of the form housed within Meditech allows for input from the HCC Hospital Care Coordinators.
Standard process for all NSM LHIN hospitals that supports a seamless transition for a patient admitted to hospital and returning home from hospital with a pain pump	Y	Through a structured analytical quality improvement exercise (pFMEA) completed with HCC staff and service providers, the process that supports a patient's admission and discharge from hospital with a pain pump was analyzed to identify and evaluate the potential failures of the process. As a result, NSM is implementing a new process that will ensure a safe and seamless transition for both new and existing patients admitted and discharged from hospital with a pain pump. It is expected that this will be completed by end of March 2019 with an evaluation continuing in to Q1 2019.
Implementation of the electronic collaborative care plan (CCP) in (HPG) for all Health Link patients	N	Progress continues in the planning and implementation of this initiative. Key deliverables included the development of a region-wide consent, a patient registration and discharge process, a guidebook for users and Health Partner Gateway (HPG) audit reports in preparation for future auditing needs. Preparation activities for onboarding of health service providers has moved more slowly than anticipated due to the work needed to complete the required privacy and security assessment, and the limited allocation of resources by organizations to this initiative. Nine organizations are in various stages of



onboarding with expectations that some organizations will be ready to go live before the end of the fiscal year. This initiative will continue into the 2019/20 fiscal year as part of the LHIN's e-health strategy.

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6	<p>Unplanned ED Visits: Percentage of Home Care patients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital</p> <p>(%; Home Care patients discharged from hospital; July 2016 – June 2017; HSSO HCD, CIHI DAD, CIHI NACRS)</p>	8.4%	7.6%	<p>8.2%</p> <p>Q1 2017/18 - Q4 2017/18</p> <p>(will be updated when results available for Q2 2017/18 – Q1 2018/19)</p>	In 2018/19, NSM LHIN continued to focus on strategies to reduce unplanned ED visits through sustaining cross organizational partnerships and the implementation of E-health strategies. NSM has improved its current performance in 2018/19 by 0.2%, though remains above target. We continue to focus on reducing unplanned ED visits in partnership with Primary Care, Health Links and our partner hospitals.

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Spread of the electronic solution for processing referrals from acute care to HCC (E-Referral)	Y	E-referral has been successfully implemented at all five hospitals within the NSM region.
Spread Telehomecare home visit pilot program currently in the Barrie sub-region to other NSM sub-regions	N	A home visit pilot program has been expanded to the Couchiching sub-region. NSM has seen an increase quarter over quarter in the percent of patients enrolled in the Telehomecare (THC) program over those referred. Due to resource capacity, spreading the home visit program to other sub-regions will not be an area of focus at this time. Other sustainable strategies will be investigated and included within the 2019/20 QIP to increase referrals and enrollments in the program.

In partnership with Paramedicine, Health Links and NSM Hospitals, streamline the referral process to Telehomecare

N

This initiative was placed on hold by Paramedicine. Pre-work was done but faced challenges in moving forward, though work continues with the hospitals and Health Links.

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7	Time to Acknowledge Complaints: % of complaints acknowledged within 2 days	N/A	Collect baseline	N/A	<p>Key focus for 2018/19 was on ensuring our current event tracking management system (ETMS) supported the tracking of time from receipt to acknowledgement of a complaint. As the South West LHIN is the owner of the ETMS system, the timing of these changes was dependent on their resource capacity. Though changes may still occur by the end of Q4 2018/19, the ability to collect baseline data electronically through ETMS for this fiscal year has not been possible. A manual audit will be completed in Q4 to determine the percent of complaints acknowledged within the target of two days. For 2019/20, this indicator will be not be included in the QIP, but will be monitored through our internal performance reporting.</p>

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<p>Evolve our Home and Community Care complaints management process in alignment with Health Quality Ontario guidelines</p>	<p>Y</p>	<p>In addition to receiving caregiver input into our process, NSM, in collaboration with other LHIN partners, has evolved our Home and Community Care complaints management process to ensure alignment with Health Quality Ontario's (HQO), "Guide to improving Complaints Processes in the Home and Community Care Sector". The NSM HCC complaints management process is included within the NSM LHIN HCC Event Management Framework.</p>

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8	Closed Diabetic Foot Ulcer % of patients with a diabetic foot ulcer that closed within a 12 week period	N/A	Collecting baseline	N/A	Implementation of the Health Quality Ontario Standard for Diabetic Foot Ulcers is currently in progress. Collection of baseline data is not yet possible. Over the next fiscal year, NSM will be working with the Provincial Wound Care Project to implement wound care pathways for our wound care-coded patients.

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Implementation of the Quality Standard for Diabetic Foot Ulcers	N	Work is being done in partnership with our hospitals to determine the plan for funding disbursement for Total Contact Casting (TCC). As well, NSM has taken the preliminary step to add wound care coding for all wound care patients. This will assist in identifying the types of wounds patients have, and to specifically isolate those with diabetic foot wounds. Several NSM Care Coordinators will be participating in the Michener Institute Course "Foot Care Management in Diabetes".